FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble
Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist States in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with States and CMS over the years to design and revise this Annual Report Template. Over time, the framework has been updated to reflect program maturation and corrected where difficulties with reporting have been identified.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: **North Carolina**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

L. Allen Dobson, Jr., MD
(Signature of Agency Head)

SCHIP Program Name(s): **North Carolina Health Choice for Children**

SCHIP Program Type:

_____ SCHIP Medicaid Expansion Only
X Separate Child Health Program Only
_____ Combination of the above

Reporting Period: ***Federal Fiscal Year 2005*** *Note: Federal Fiscal Year 2005 starts 10/1/04 and ends 9/30/05.*

Contact Person/Title: Cinnamon H. Narron, MPA / Coordinator

Address: **Division of Medical Assistance, 2501 Mail Service Center Raleigh, NC 27699-2501**

Phone: **(919) 855-4000** Fax: **(919) 715-0801**

Email: **Cinnamon.narron@ncmail.net**

Submission Date: _____

SECTION I: SNAPSHOT OF SCHIP PROGRAM AND CHANGES

1) To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. You are encouraged to complete this table for the different SCHIP programs within your state, e.g., if you have two types of separate child health programs within your state with different eligibility rules. If you would like to make any comments on your responses, please explain in narrative below this table. Please note that the numbers in brackets, e.g., **[500]** are character limits in the State Annual Report Template System (SARTS). You will not be able to enter responses with characters greater than the limit indicated in the brackets.

	SCHIP Medicaid Expansion Program					Separate Child Health Program				
Eligibility						From	n/a	% of FPL conception to birth	n/a	% of FPL
	From		% of FPL for **infants**		% of FPL	From	185	% of FPL for **infants**	200	% of FPL
	From		% of FPL for children ages **1 through 5**		% of FPL	From	133	% of FPL for 1 **through 5**	200	% of FPL
	From		% of FPL for children ages **6 through 16**		% of FPL	From	100	% of FPL for children ages **6 through 16**	200	% of FPL
	From		% of FPL for children ages **17 and 18**		% of FPL	From	100	% of FPL for children ages **17 and 18**	200	% of FPL

Is presumptive eligibility provided for children?		No	X	No
		Yes, for whom and how long?		Yes, for whom and how long?

Is retroactive eligibility available?		No	X	No
		Yes, for whom and how long?		Yes, for whom and how long?

Does your State Plan contain authority to implement a waiting list?	Not applicable		No
		X	Yes

Does your program have a mail-in application?		No		No
		Yes	X	Yes

Can an applicant apply for your program over the phone?		No	X	No
		Yes		Yes

Does your program have an application on your website that can be printed, completed and mailed in?		No		No
		Yes	X	Yes

Can an applicant apply for your program on-line?		No	X	No
	Yes – please check all that apply		Yes – please check all that apply	
		Signature page must be printed and mailed in		Signature page must be printed and mailed in
		Family documentation must be mailed (i.e., income documentation)		Family documentation must be mailed (i.e., income documentation)
		Electronic signature is required		Electronic signature is required
				No Signature is required

Does your program require a face-to-face interview during initial application?		No	X	No
		Yes		Yes

Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?		No	X	No
		Yes		Yes
	Specify number of months		Specify number of months	

Does your program provide period of continuous coverage <u>regardless of income changes?</u>		No		No
		Yes	X	Yes
	Specify number of months		Specify number of months	12
	Explain circumstances when a child would lose eligibility during the time period in the box below		Explain circumstances when a child would lose eligibility during the time period in the box below	
	[1000]		Acquires comprehensive health insurance or Medicare, moves out of state, dies, requests termination of assistance, turns age 19, incarcerated, becomes eligible for TANF, removed from the home by department of social services for placement, approved for SSI Medicaid, or is pregnant and eligible for coverage under MPW, MIC, or MAF.	

Does your program require premiums or an enrollment fee?		No		No
		Yes	X	Yes
	Enrollment fee amount		Enrollment fee amount	**$50 per child / $100 for two or more**
	Premium amount		Premium amount	
	Yearly cap		Yearly cap	

	If yes, briefly explain fee structure in the box below	If yes, briefly explain fee structure in the box below (including premium/enrollment fee amounts and include Federal poverty levels where appropriate)
	[500]	**The enrollment fee is $50 for one child or $100 for two or more children. Enrollment fee is required of families whose income is at or above 150% of the FPL.**

Does your program impose copayments or coinsurance?		No		No
		Yes	**X**	Yes

Does your program impose deductibles?		No	**X**	No
		Yes		Yes

Does your program require an assets test?		No	**X**	No
		Yes		Yes
	If Yes, please describe below		If Yes, please describe below	
	[500]			

Does your program require income disregards?		No		No
		Yes	**X**	Yes
			If Yes, please describe below	
			$90 standard income disregard for each working adult, $175 child care deduction for each child over age two, $200 child care deduction for each child age two and under.	

Is a preprinted renewal form sent prior to eligibility expiring?		No	**X**	No
	Yes, we send out form to family with their information pre-completed and		Yes, we send out form to family with their information pre-completed and	
		We send out form to family with their information pre-completed and ask for confirmation		We send out form to family with their information pre-completed and ask for confirmation
		We send out form but do not require a response unless income or other circumstances have changed		We send out form but do not require a response unless income or other circumstances have changed

Comments on Responses in Table:

2.	Is there an assets test for children in your Medicaid program?		Yes	X No
3.	Is it different from the assets test in your separate child health program?		Yes	X No
4.	Are there income disregards for your Medicaid program?	X	Yes	No
5.	Are they different from the income disregards in your separate child health program?		Yes	X No
6.	Is a joint application used for your Medicaid and separate child health program?	X	Yes	No

7. Have you made changes to any of the following policy or program areas during the reporting period? Please indicate "yes" or "no change" by marking appropriate column.

	Medicaid Expansion SCHIP Program		Separate Child Health Program	
	Yes	No Change	Yes	No Change
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)				X
b) Application				X
c) Benefit structure				X
d) Cost sharing (including amounts, populations, & collection process)				X
e) Crowd out policies				X
f) Delivery system				X
g) Eligibility determination process (including implementing a waiting lists or open enrollment periods)				X
h) Eligibility levels / target population				X
i) Assets test in Medicaid and/or SCHIP				X
j) Income disregards in Medicaid and/or SCHIP				X
k) Eligibility re-determination process				X

l) Enrollment process for health plan selection				X
m) Family coverage				X
n) Outreach (e.g., decrease funds, target outreach)				X
o) Premium assistance				X
p) Prenatal Eligibility expansion				X
q) Waiver populations (funded under title XXI)				X
Parents				
Pregnant women				
Childless adults				
r) Other – please specify				
a. **[50]**				
b. **[50]**				
c. **[50]**				

8. For each topic you responded yes to above, please explain the change and why the change was made, below:

a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	
b) Application	
c) Benefit structure	
d) Cost sharing (including amounts, populations, & collection process)	
e) Crowd out policies	
f) Delivery system	

g) Eligibility determination process (including implementing a waiting lists or open enrollment periods)	
h) Eligibility levels / target population	
i) Assets test in Medicaid and/or SCHIP	
j) Income disregards in Medicaid and/or SCHIP	
k) Eligibility redetermination process	
l) Enrollment process for health plan selection	
m) Family coverage	
n) Outreach	
o) Premium assistance	
p) Prenatal Eligibility Expansion	
q) Waiver populations (funded under title XXI)	
Parents	
Pregnant women	
Childless adults	
r) Other – please specify	
a. **[50]**	
b. **[50]**	
c. **[50]**	

SECTION II: PROGRAM'S PERFORMANCE MEASUREMENT AND PROGRESS

This section consists of three sub sections that gather information on the core performance measures for the SCHIP program as well as your State's progress toward meeting its general program strategic objectives and performance goals. Section IIA captures data on the core performance measures to the extent data are available. Section IIB captures your enrollment progress as well as changes in the number and/or rate of uninsured children in your State. Section IIC captures progress towards meeting your State's general strategic objectives and performance goals.

Please note that the numbers in brackets, e.g., [500] are character limits in the State Annual Report Template System (SARTS). You will not be able to enter responses with characters greater than the limit indicated in the brackets.

SECTION IIA: REPORTING OF CORE PERFORMANCE MEASURES

CMS is directed to examine national performance measures by the SCHIP Final Rules of January 11, 2001. To address this SCHIP directive, and to address the need for performance measurement in Medicaid, CMS, along with other Federal and State officials, developed a core set of performance measures for Medicaid and SCHIP. The group focused on well-established measures whose results could motivate agencies, providers, and health plans to improve the quality of care delivered to enrollees. After receiving comments from Medicaid and SCHIP officials on an initial list of 19 measures, the group recommended seven core measures, including four child health measures and three adult measures:

Child Health Measures
- Well child visits in the first 15 months of life
- Well child visits in the 3rd, 4th, 5th, and 6th years of life
- Use of appropriate medications for children with asthma
- Children's access to primary care practitioners

Adult Measures
- Comprehensive diabetes care (hemoglobin A1c tests)
- Adult access to preventive/ambulatory health services
- Prenatal and postpartum care (prenatal visits)

These measures are based on specifications provided by the Health Plan Employer Data and Information Set (HEDIS®). HEDIS® provides a useful framework for defining and measuring performance. However, use of HEDIS® methodology is not required for reporting on your measures. The HEDIS® methodology can also be modified based on the availability of data in your State.

The table should be completed as follows:

Column 1: If you cannot provide a specific measure, please check the boxes that apply to your State for each performance measure, as follows:
- Population not covered: Check this box if your program does not cover the population included in the measure. For example, if your State does not cover adults under SCHIP, check the box indicating, "population not covered" for the three adult measures.
- Data not available: Check this box if data are not available for a particular measure in your State. Please provide an explanation of why the data are currently not available.
- Not able to report due to small sample size: Check this box if the sample size (i.e., denominator) for a particular measure is **less than 30**. If the sample size is less 30, your State is not required to report data on the measure. However, please indicate the exact sample size in the space provided.
- Other: Please specify if there is another reason why your state cannot report the measure.

Column 2: For each performance measure listed in Column 1, please indicate the measurement specification (i.e., were the measures calculated using the HEDIS® technical specifications, HEDIS®-like specifications, or some other source with measurement specifications unrelated to HEDIS®). If the measures were calculated using HEDIS® or HEDIS®-like specifications, please indicate which version was used (e.g., HEDIS® 2004).

Column 3: For each performance measure listed in Column 1, please indicate the data source(s); the definition of the population included in the measure (such as age, continuous enrollment, type of delivery system); the baseline measurement and baseline year; and your current performance, including the date of the most recent data reported. For rates, please specify the numerator and denominator that were used to calculate the rates. Please also note any comments on the performance measures or progress, such as data limitations, comparisons with external benchmarks, etc. and an explanation for changes from the baseline. Note: you do not need to report data for all delivery system types. You may choose to report data for only the delivery system with the most enrollees in your program.

NOTE: **Please do not reference attachments in this table. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.**

Measure	Measurement Specification	Performance Measures and Progress
Well child visits in the first 15 months of life Not Reported Because: □ Population not covered □ Data not available Explain: X Not able to report due to small sample size (less than 30) Specify sample size: 24 □ Other Explain: **[500]**	□ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress/Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**

Measure	Measurement Specification	Performance Measures and Progress
Well child visits in children the 3rd, 4th, 5th, and 6th years of life Not Reported Because: □ Population not covered □ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain: **[500]**	☒ HEDIS Specify version of HEDIS used: HEDIS 2005 specifications (administrative specification) □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): North Carolina DRIVE data warehouse. TABLES: CLIENT_POPULATION (eligibility) CLIENT (recipient) HEALTH_CHOICE_CLAIMS (claims). Claims data from 01/01/2004 – 12/31/2004. Definition of Population Included in Measure: Ages – Three, four, five or six years old as of December 31 of 2004. Continuous Enrollment – Continuously enrolled during 2004. Allowable gap –Member may not have more than a 1-month gap in coverage to be included in this measure. Anchor Date – Enrolled as of December 31 of 2004. Delivery System of Care – (Health Choice). Baseline / Year: (Specify numerator and denominator for rates) NC Health Choice submitted data for this measure for 2002 claims data (submitted end-of-year 2003). The data submitted will serve as baseline. 2002 rate – Numerator 3,814 = 55.50% Denominator 6,872 Performance Progress/Year: (Specify numerator and denominator for rates) In this report, NC Health Choice submits data for this measure for 2004 claims data. 2004 rate – Numerator 6,707 = 56.73% Denominator 11,823 Explanation of Progress: **We have seen an increase in the population while also seeing an increase in the percentage of kids getting their well child checkups.**

<table>
<tr><th>Measure</th><th>Measurement Specification</th><th>Performance Measures and Progress</th></tr>
<tr><td></td><td></td><td>Other Comments on Measure:
Further definition of the claims selected:
<table><tr><th>Selected claims with following places-of-service</th></tr><tr><td>OUTPATIENT DEPT</td></tr><tr><td>OFFICE</td></tr><tr><td>PATIENT'S HOME</td></tr><tr><td>OTHER</td></tr></table>
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<table><tr><th colspan="2">Only allowed the following billing provider specialty codes when determining well child visits :</th></tr><tr><td>GP-GENERAL PRACTICE</td><td>012</td></tr><tr><td>I-INTERNAL MEDICINE</td><td>015</td></tr><tr><td>PEDIATRICS</td><td>030</td></tr><tr><td>PH-PUBLIC HEALTH</td><td>031</td></tr><tr><td>FP-FAMILY PRACTICE</td><td>041</td></tr><tr><td>MSP-MULTISPEC OR PDC</td><td>100</td></tr><tr><td>I-INTERNAL MED GROUP</td><td>115</td></tr><tr><td>PD-PEDIATRICS GROUP</td><td>130</td></tr><tr><td>INTERNAL MEDICINE</td><td>188</td></tr><tr><td>FAMILY NURSE PRACTITIONER</td><td>190</td></tr></table></td></tr>
<tr><td>Use of appropriate medications for children with asthma

Not Reported Because:

□ Population not covered
□ Data not available
Explain:
□ Not able to report due to small sample size (less than 30)
Specify sample size:
□ Other
Explain:

[500]</td><td>☒ HEDIS
Specify version of HEDIS used:
HEDIS 2005 Specifications
□ HEDIS-Like
Explain how HEDIS was modified:

Specify version of HEDIS used:

□ Other
Explain:

[7500]</td><td>Data Source(s):
NC SCHIP membership and claims data

Definition of Population Included in Measure:
Members age 5-19 (by December 31, 2004, continuously enrolled in both calendar years 2003 and 2004 (with no more than one month gap in enrollment) defined as persistent asthmatics (per NCQA specifications).

Baseline / Year: 2002 Measurement year
(Specify numerator and denominator for rates)
5- 9 year olds 175/258 (67.83%)
10-17 year olds 312/493 (63.29%)
18-19 year olds 19/37 (51.35%)
Combined 506/788 (64.21%)</td></tr>
</table>

Measure	Measurement Specification	Performance Measures and Progress
		Performance Progress/Year: **2004** (Specify numerator and denominator for rates) **5- 9 year olds 556/700 (79.43%)** **10-17 year olds 974/1297 (75.10%)** **18-19 year olds 42/76 (55.26%)** **Combined 572/2073 (75.83%)** Explanation of Progress: **The Asthma Intervention Plan implemented by the NC State Health Plan continues to improve the measure.** Other Comments on Measure:
Children's access to primary care practitioners Not Reported Because: □ Population not covered □ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain:	X HEDIS Specify version of HEDIS used: HEDIS 2005 specifications (administrative specification) □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain:	Data Source(s): North Carolina DRIVE data warehouse. TABLES: CLIENT_POPULATION (eligibility) CLIENT (recipient) HEALTH_CHOICE_CLAIMS (claims). Age stratification 1 and 2 - Claims data from 01/01/2004 – 12/31/2004. Age stratification 3 and 4 - Claims data from 01/01/2003 – 12/31/2004. **[500]**

Measure	Measurement Specification	Performance Measures and Progress
[500]	**[7500]**	Definition of Population Included in Measure: Ages Age stratification 1 - 12-24 months as of December 31, 2004. Age stratification 2 - 25 months to 6 years as of December 31, 2004. Age stratification 3 - 7-11 years as of December 31, 2004. Age stratification 4 - 12-19 years as of December 31, 2004. Continuous Enrollment Age stratifications 1 and 2 - Continuously enrolled for all of 2004. Age stratifications 3 and 4 - Continuously enrolled for all of 2003 and 2004. Allowable gap Age stratifications 1 and 2 - No more than 1 month gap for the measurement year. Age stratifications 3 and 4 - No more than 1 month gap during each year of continuous enrollment. Anchor date – Enrolled as of December 31, 2004. Delivery System of Care – (HealthChoice). **[700]**

Measure	Measurement Specification	Performance Measures and Progress
		Baseline / Year: (Specify numerator and denominator for rates) NC HealthChoice submitted data for this measure for 2002 claims data (submitted end-of-year 2003). The data submitted will serve as baseline. 2002 rates – Age stratification 1 Numerator 574 = 96.80% Denominator 593 Age stratification 2 Numerator 7,380 = 89.86% Denominator 8,213 Age stratification 3 Numerator 8,173 = 89.55% Denominator 9,127 Age stratification 4 was new for HEDIS 2004. Baseline rate for 2003 data. Age stratification 4 Numerator 12,404 = 85.36% Denominator 14,532 [Performance Progress/Year: (Specify numerator and denominator for rates) In this report, NC HealthChoice submits data for this measure for 2004 claims data. 2004 rates – Age stratification 1 Numerator 730 = 96.43% Denominator 757 Age stratification 2 Numerator 12,672 = 88.73% Denominator 14,281 Age stratification 3 Numerator 12,146 = 90.53% Denominator 13,416 Age stratification 4 Numerator 15,911 = 85.79% Denominator 18,546 Explanation of Progress: **The rates remain the same with the increasing population.**

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<tr><td>Adult Comprehensive diabetes care (hemoglobin A1c tests)

Not Reported Because:

☒ Population not covered
□ Data not available
Explain:
□ Not able to report due to small sample size (less than 30)
Specify sample size:
□ Other
Explain:
[500]</td><td>□ HEDIS
Specify version of HEDIS used:

□ HEDIS-Like
Explain how HEDIS was modified:

Specify version of HEDIS used:

□ Other
Explain:

[7500]</td><td>Data Source(s):
[500

Definition of Population Included in Measure:
[700]
Baseline / Year:
(Specify numerator and denominator for rates)
[500]
Performance Progress/Year:
(Specify numerator and denominator for rates)
[7500]
Explanation of Progress:
[700]

Other Comments on Measure:
[700]</td></tr>
</table>

Measure	Measurement Specification	Performance Measures and Progress
Adult access to preventive/ambulatory health services Not Reported Because: ☒ Population not covered □ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain: **[500]**	□ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress/Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
Adult Prenatal and postpartum care (prenatal visits): □ **Coverage for pregnant women over age 19 through a demonstration** □ **Coverage for unborn children through the SCHIP state plan** □ **Coverage for pregnant women under age 19 through the SCHIP state plan** Not Reported Because: ☒ Population not covered □ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain: **[500]**	□ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress/Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**

SECTION IIB: ENROLLMENT AND UNINSURED DATA-THIS INFORMATION IS PRELOADED ONTO SARTS

1. The information in the table below is the Unduplicated Number of Children Ever Enrolled in SCHIP in your State for the two most recent reporting periods. The enrollment numbers reported below should correspond to line 7 in your State's 4th quarter data report (submitted in October) in the SCHIP Statistical Enrollment Data System (SEDS). The percent change column reflects the percent change in enrollment over the two-year period. If the percent change exceeds 10 percent (increase or decrease), please explain in letter A below any factors that may account for these changes (such as decreases due to elimination of outreach or increases due to program expansions). This information will be filled in automatically by SARTS through a link to SEDS. Please wait until you have an enrollment number from SEDS before you complete this response.

Program	FFY 2004	FFY 2005	Percent change FFY 2004-2005
SCHIP Medicaid Expansion Program	**n/a**	**n/a**	**n/a**
Separate Child Health Program	**174,259**	**195,918**	**12.4%**

A. Please explain any factors that may account for enrollment increases or decreases exceeding 10 percent.

Increases in enrollment result from the continued increase in the migrant population with SCHIP eligible children in the state and the rising costs of private health insurance. Overall the percentage of children age 0-18 with family income at or below 200 % of the FPL dropped three percent from FFY 2004 to FFY 2005.

2. Three-year averages in the number and/or rate of uninsured children in each state based on the Current Population Survey (CPS) are shown in the table below, along with the percent change between 1996-1998 and 2001-2004. Significant changes are denoted with an asterisk (*). If your state uses an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please explain in Question #3. SARTS will fill in this information automatically.

	Uninsured Children Under Age 19 Below 200 Percent of Poverty		Uninsured Children Under Age 19 Below 200 Percent of Poverty as a Percent of Total Children Under Age 19	
Period	Number	Std. Error	Rate	Std. Error
1996-1998	**212**	**29.3**	**11.2**	**1.5**
1997-1999	**195**	**27.8**	**10.2**	**1.4**
2000-2002	**166**	**22**	**7.7**	**1.0**
2001-2003	**177**	**23.4**	**8.2**	**1.0**
Percent change 1996-1998 vs. 2001-2004	**-13.2%**	NA	**-24.1%**	NA

A. Please note any comments here concerning CPS data limitations that may affect the reliability or precision of these estimates.

3. If your State has an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please report in the table below. Data are required for two or more points in time to demonstrate change (or lack of change). Please be as specific and detailed as possible about the method used to measure progress toward covering the uninsured.

Data source(s)	**[500]**
Reporting period (2 or more points in time)	
Methodology	**[7500]**
Population	
Sample sizes	**Not applicable**
Number and/or rate for two or more points in time	
Statistical significance of results	**[200]**

A. Please explain why the state chose to adopt a different methodology to measure changes in the number and/or rate of uninsured children.

n/a

B. What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Provide a numerical range or confidence intervals if available.)

n/a

4. How many children do you estimate have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information. ***(States with only a SCHIP Medicaid Expansion Program should skip this question)***

Since the implementation of NC Health Choice, October 1, 1998, through July 1, 2005, a total of 1,023,766 children have applied for Medicaid using the joint application for Medicaid and Health Choice. Of these, 786,908 have been enrolled in Medicaid. During the same time period, 662,285 children have been evaluated for Health Choice on the same joint application. Of these, 466,311 have been enrolled in Health Choice. An additional 432,125 children were enrolled in Medicaid through other programs.

SECTION IIC: STATE STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

In the table below, summarize your State's general strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Use additional pages as necessary. **Please do not reference attachments in this table. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.** The table should be completed as follows:

Column 1: List your State's general strategic objectives for your SCHIP program and indicate if the strategic objective listed is new/revised or continuing. If you have met your goal and/or are discontinuing a strategic objective or goal, please continue to list the objective/goal in the space provided below, and indicate that it has been discontinued, and provide the reason why it was discontinued. Also, if you have revised a goal, please check "new/revised" and explain how and why it was revised.

Note: States are required to report objectives related to reducing the number of uninsured children. (This/these measure(s) should reflect what was reported in Section IIB, Question(s) 2

and 3. <u>Progress</u> towards reducing the number of uninsured children should be reported in this section.)

Column 2: List the performance goals for each strategic objective. Where applicable, provide the measurement specification (i.e., were the measures calculated using the HEDIS® technical specifications, HEDIS®-like specifications, or some other source with measurement specifications unrelated to HEDIS®).

Column 3: For each performance goal listed in Column 1, please indicate the data source(s); the definition of the population included in the measure (such as age, continuous enrollment, type of delivery system); the methodology used; the baseline measurement and baseline year; and your current performance, including the date of the most recent data reported. For rates, please specify the numerator and denominator that were used to calculate the rates. Please note any comments on the performance measures or progress, such as data limitations, comparisons with external benchmarks, or the like.

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
Objectives Related to Reducing the Number of Uninsured Children *(Mandatory for all states for each reporting year) (This/these measure(s) should reflect what was reported in Section IIB, Question(s) 2 and 3.)*		
□ New/revised X Continuing □ Discontinued Explain:	Goal #1: **Reduce the number of uninsured children.**	Data Source(s): **[500]** Definition of Population Included in Measure: **All children ages 0-18 in the state of North Carolina who live in families with incomes below 200% FPL.** Methodology: **[500]** Baseline / Year: **14.5%/FFY 1999** (Specify numerator and denominator for rates) **Numerator- 119,081 (estimated number of uninsured children ages 0-18 in families with income below 200%FPL)** **Denominator – 820,528(total children ages 0-18)** Performance Progress / Year: **Percent uninsured in FFY 2005 – 7.6%** (Specify numerator and denominator for rates) **Numerator – 173,000 (estimated number of uninsured children ages 0-18 in families with income below 200% FPL)** **Denominator – 2,268,000 (total children ages 0-18)** Explanation of Progress: **North Carolina continues to increase enrollment in both and Medicaid and SCHIP and decreasing the number of uninsured children.** Other Comments on Measure: **North Carolina has previously used an alternative methodology for measuring the uninsured. This year, we are using the CPS to measure the uninsured.**

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #2: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #3: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**

Objectives Related to SCHIP Enrollment

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
□ New/revised X Continuing □ Discontinued Explain:	Goal #1: **To maintain SCHIP enrollment to fundable levels.**	Data Source(s): **Monthly reports on number of SCHIP eligible children and monthly budget reports.** Definition of Population Included in Measure: **The actual children enrolled in North Carolina Health Choice.** Methodology: **State and counties monitor enrollment and spending.** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **No freeze has been implemented in FFY2005** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #2: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #3: **[7500]**	Data Source(s):**[500]** Definition of Population Included in Measure:**[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
Objectives Related to Medicaid Enrollment		
□ New/revised X Continuing □ Discontinued Explain: **[500]**	Goal #1: **To enroll a full measure of children in Medicaid.**	Data Source(s): **The Division of Medical Assistance Eligibility Information System (EIS).** Definition of Population Included in Measure: **Children enrolled in the MIC category of Medicaid. These are children enrolled as the result of applying for health insurance on the combined Medicaid and Health Choice application form.** Methodology: **Compare the number of children enrolled as of the end of the federal fiscal year to children enrolled just before the Health Choice program began in 1998.** Baseline / Year: **1998** (Specify numerator and denominator for rates) **Numerator = 231,891. October 1, 1998: 231,891 eligible children in MIC (Medicaid Indigent Children). North Carolina Health Choice for Children opened on this date.** **Denominator = October 1, 2005: 413,666 eligible children in MIC.** Performance Progress / Year: **2005** (Specify numerator and denominator for rates) **There are now 181,775 more children enrolled in Medicaid than there were when NC Health Choice opened. The number of children enrolled is 78% greater than in 1998.** Explanation of Progress: **The combined outreach for the Children's Medicaid program with NC Health Choice has steadily grown both programs.** Other Comments on Measure: **[700]**

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #2: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #3: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
□ New/revised X Continuing □ Discontinued Explain: **[500]**	Goal #1: **Increase the access to primary care physicians. (Please see HEDIS data reported in IIA.** □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used:	Data Source(s): **See Section IIA.** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]**

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
	□ Other Explain: **[7500]**	Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #2: □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #3: □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
□ New/revised X Continuing □ Discontinued Explain: **[500]**	Goal #1: **Improve the number of well child visits.** □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **Please see Section IIA. above.** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
□ New/revised X Continuing □ Discontinued Explain: **The state immunization registry began rollout in June 2005 and is not available to provide sufficient data on Health Choice children. Therefore, only statewide data is available. According to the 2005 Child Health Report Card published by the NC Institute of Medicine, the immunization rate of all two-year old children is 82.9%. The rate for all children at school entry is 99.1%**	Goal #2: **Improve immunization rates.** □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain:	Data Source(s): Definition of Population Included in Measure: Methodology: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress / Year: (Specify numerator and denominator for rates) Explanation of Progress: **[700]** Other Comments on Measure: **[700]**

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #3: □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**

1. What other strategies does your state use to measure and report on access to, quality, or outcomes of care received by your SCHIP population? What have you found? **Periodic studies, however none in 2005.**

2. What strategies does your SCHIP program have for future measurement and reporting on access to, quality, or outcomes of care received by your SCHIP population? When will data be available?

The Child Health Assessment and Monitoring Program (CHAMP) survey has been undertaken by the State Center for Health Statistics to measure the health characteristics of children age 0-17. This data includes information on children receiving SCHIP but will not be available until Spring 2006. We will share this information in next year's annual report.

Utilization statistics are provided for the North Carolina Health Choice Program on a quarterly basis. These reports provide demographics, utilization and cost data related to Health Choice participants. These reports will be shared with the Provider Task Force for comment and feedback. Other means for measuring the care received by Health Choice participants include monthly and quarterly claims data reports from Blue Cross Blue Shield and monthly reports from Value Options regarding behavioral health services.

3. Have you conducted any focused quality studies on your SCHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special heath care needs or other emerging health care needs? What have you found? **No studies have been conducted.**

4. Please attach any additional studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here and summarize findings or list main findings.

A survey conducted in May of 2005 at the request of the NC General Assembly looked at where Health Choice families work. The survey showed 1.5 wage earners per child in NC Health Choice. Some workers reported holding more than two jobs. The two highest areas of employment were factory work and health care. Ranking next was construction, city or county employment, restaurant employment, self-employment, discount store employment, public school and state employment, day care, hotel/motel employment, farming or farm work, federal employment and military.

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

Please reference and summarize attachments that are relevant to specific questions

Please note that the numbers in brackets, e.g., **[7500]** are character limits in the State Annual Report Template System (SARTS). You will not be able to enter responses with characters greater than the limit indicated in the brackets.

OUTREACH

1. How have you redirected/changed your outreach strategies during the reporting period?

Our outreach strategies continue to fall under three main areas of focus, but how we prioritize those efforts has shifted slightly. They are as follows:

1) Encouraging families to make the best use of their health insurance benefit once they are enrolled.
2) Direct outreach to families and those who serve families, including targeted outreach to children with special health care needs and minority populations.
3) Simplification of enrollment / re-enrollment processes.

In July 2004, North Carolina launched a Medical Home Campaign similar in scope and target audiences to the launch of the NC Health Choice (SCHIP) Program back in 1998. One significant difference is that this time we had access to list serves and the ability to hyperlink to our Health Check (Medicaid) / NC Health Choice Outreach Web Site where "News" is posted resulting in a much faster distribution of information. Nearly 1,400,000 Medical Home education materials were distributed in the first 12 months. The Campaign defines and highlights the importance of having a "medical home" for all of a child's preventive and primary health care needs. It encourages families, especially those newly enrolled in Health Check / NC Health Choice (HC/NCHC), to establish their medical home by going for regular well child checkups. Through "The Right Call Every Time" logo and tag line, it encourages families to use their medical home for primary care, not the emergency room, and defines when use of the ER is appropriate. For Children with Special Health Care Needs, it emphasizes the importance of a medical home in coordinating all of a child's health care needs. All outreach efforts related to this initiative highlight key messages of the Medical Home and HC/NCHC Outreach Campaigns.

Now that NC Health Choice is entering its 8th year, direct outreach to families and those who serve families has become institutionalized. Our most effective strategy has been outreach through schools and child care centers. Back to school enrollment drives, pre-K orientations, linkages with school lunch program outreach, and PTA meetings provide great opportunities. Most importantly, staying on the radar of school nurses, counselors, psychologists, social workers, and other school staff through exhibits/breakout sessions at conferences, direct mail, list serves, and web links is critical to maintaining a focus on outreach for these programs.

The child care community is targeted through Child Care Directors, Early Childhood Educators, Health Consultants, Resource and Referral Agencies, the Head Start, More At Four, and Smart Start Programs, and others through exhibits/breakout sessions at conferences, participation in new staff orientations, electronic post cards distributed through list serves, direct mailings and other methods. HC/NCHC is also marketed in state Early Child Care Directories. Our State's TEACCH Early Childhood Education Project continues to provide incentives for getting uninsured children of low wage child care staff covered through the State's child health insurance programs. As opportunities arise, we continue to work with the business and faith communities, but have found these efforts to be more labor intensive and low yield for general outreach, although appropriate for targeted minority outreach (see question 3 for outreach to targeted populations).

North Carolina is blessed to have local Health Check Coordinators (HCCs) in 88 out of 100 counties (approximately 105 positions statewide) who spearhead grassroots outreach for our publicly-funded child health insurance programs. HCCs are a critical component in NC's efforts to institutionalize and

sustain outreach. Through a seamless process, children are enrolled in Health Check (Medicaid) or NC Health Choice (SCHIP) through a single (mail-in option) application form. Local departments of social services process these applications reviewing for Medicaid first, and then SCHIP for those who do not qualify for Medicaid.

An important strategy in successful outreach, enrollment, and re-enrollment continues to be the simplification of enrollment and re-enrollment processes. State outreach staff continues to work collaboratively with staff at the NC Division of Medical Assistance to develop family-friendly, low literacy, simplified and Title VI compliant notices, application forms and re-enrollment forms. A new HC/NCHC Re-enrollment Form was developed and focus-tested with families and will be implemented in the coming months. A joint Medicaid/Food Stamp Application has been developed and pilot-tested by one of NC's local *Covering Kids and Families* projects.

The NC Healthy Start Foundation, a statewide non-profit with whom the Division of Public Health contracts for their campaign and materials development expertise, redesigned their web site this year in honor of their 15th anniversary. The Child Health Insurance Public Web Site (http://www.nchealthystart.org/public/childhealth/index.htm) received an overhaul as a part of this process. The site is continuously updated and receives a thorough annual review for accuracy and functionality. It provides online information, links to resources (application forms; benefits booklets) for families and the public.

The HC/NCHC Outreach Web Site (http://www.NCHealthyStart.org/outreach/index.html) serves as a One-Stop-Shop for information and resources for folks doing outreach statewide. The web site continues to be updated with "News"; links to data and resources; "experiences to share" and "local contact information." This web site combined with the state-created outreach list serve (distribution 1,000+ individuals) continues to offer a powerful and responsive communication vehicle. Single-issue urgent communications, announcements of new articles on the web site (with links), and annual surveys to update and improve our offering of outreach materials are disseminated this way.

The DMA NC Health Choice Web Site (http://www.dhhs.state.nc.us/dma/cpcont.htm) continues to be a primary resource for professionals, administrators and the public for a wealth of information regarding our State's CHIP Program.

The NC Family Health Resource Line (NC's Title V Line) is the "call to action" on all outreach materials and receives calls transferred from the National Insure Kids Now line. It is a bilingual line, with TTY for the hearing impaired, offering information, referral, and advocacy services. With a 94% service level for the 38,305 calls received in SFY 04-05, approximately 67% of the calls and 74% of the materials mailed pertained to HC/NCHC. Through the NCFHRL, we learn quickly about problems families are experiencing in getting enrolled and accessing services. They continue to serve as our "eyes and ears", allowing us to intervene on their behalf and resolve larger system issues as we note trends in problem calls.

The State and the NC Healthy Start Foundation have partnered with two grant-funded initiatives (RWJF's *Covering Kids and Families* and a Rex Foundation Project) to pilot and accomplish our joint objectives. The NC Coalition to Promote Health Insurance for Children guides our efforts and assists in work plan development.

2. What methods have you found most effective in reaching low-income, uninsured children (e.g., T.V., school outreach, word-of-mouth)? How have you measured effectiveness? **[7500]**

North Carolina continues to find that outreach through local departments of health and social services, schools, child care centers, health care professionals, and targeted outreach to special populations (including minorities and families who have children with special health care needs) are our most effective outreach strategies. This belief was informed by "lessons learned" from our first cycle of RWJF "*Covering Kids*" Funding in their final report entitled "*NC Covering Kids: A Retrospective*." In addition, we can monitor the impact of outreach efforts through the volume of HC/NCHC calls to the NC Family Health Resource Line, from logged responses to a question asked of callers, "How did you learn about the resource line?", and from data collected by the NC Healthy

Start Foundation regarding materials distribution. The continued growth of our SCHIP enrollment is also indicative of the success of our overall efforts.

The local departments of social services continue to be key to outreach / enrollment success as they work with families who apply for various programs and recognize the opportunity to enroll children in either Health Check (Medicaid) or NC Health Choice (SCHIP). Our seamless outreach /enrollment / re-enrollment process assures that children transition between the two programs successfully as their family's economic situation fluctuates. All outreach / enrollment materials work for both programs. The same computer system (EIS) is used to track the eligibility status of children in these programs. These systems continue to ensure that once children are enrolled in either program, their continued eligibility is determined through a seamless process.

3. Is your state targeting outreach to specific populations (e.g., minorities, immigrants, and children living in rural areas)? Have these efforts been successful, and how have you measured effectiveness? **[7500]**

   In North Carolina, Health Check/NC Health Choice (HC/NCHC) and Medical Home (MH) outreach is targeted to minority and immigrant populations and to families who have children with special health care needs. State efforts are also targeted geographically based on GIS Maps that show statewide patterns of population density by race/ethnicity.

   There are two positions that work on outreach to minority populations: a State Health Check/NC Health Choice Minority Outreach Consultant (Division of Public Health) and a Latino Outreach Coordinator (NC Healthy Start Foundation). Both positions do state, regional and community level outreach targeting families and those who serve them in the health, private not-for-profit, business, and faith communities.

   All of the outreach materials for the HC/NCHC and MH Campaigns are bilingual, and a Hmong HC/NCHC Fact Sheet is being developed. Leaders in minority communities are also included on our State Outreach List Serve.

   The Latino community is a rapidly growing population in North Carolina and has been a major focus of minority outreach efforts. In FY 2005, direct outreach to families was done primarily at Latino festivals and events, through community-based organizations, and through Mobile Mexican and Guatemalan Consulates. In North Carolina, Latino mobile consulates travel to areas where there is a high density of their target population to offer services and link to resources. Latino media were also heavily used to target our HC/NCHC and MH messages. The Univision television station worked with state staff to create 7 public service announcements which aired this spring. Latino radio stations aired public service announcements and interviewed staff on talk shows. Several print media outlets published feature stories and marketing pieces. Key partners with Latino outreach have been a host of community-based organizations, the NC Community Health Center Association's Latino / Migrant Health Workgroup, the NC Institute of Medicine's Latino Health Task Force, the NC Office of Minority Health and Health Disparities Latino Health Task Force, the NC Hispanic Chamber of Commerce, the State Latino Health Coalition/Center for International Understanding, the Association of Latino Professionals for Health Education, and the Office of Rural Health's Migrant Health Project and Migrant Health Sites.

   The greatest challenges in working with the Latino community are trying to explain how health insurance works, how immigration issues impact eligibility for public insurance, and how to navigate our complex health care system.

   In FY 05, a Fotonovela (Spanish picture story) was developed as a "bridge" piece to address these challenges. This funny and informative booklet explains the differences in how the health care system in the United States works as compared to Latino countries. It describes what health insurance is, how to apply for HC/NCHC, the importance of re-enrolling each year, and encourages use of a medical home.

   Outreach is targeted to refugees from a host of countries through organizations that serve them, including the Refugee Resettlement Advisory Council. The United Hmong Association has partnered with the State to enroll children in Hmong communities in HC/NCHC. The United Hmong Association

(UHA) has also worked with health care providers to explain Hmong health practices and beliefs so that care can be offered in a culturally competent manner. Through the UHA, the State HC/NCHC Minority Outreach Consultant has been invited to a Hmong New Year Celebration and other cultural events and gatherings. The Director continues to disseminate information through the 18 Hmong clan leaders.

Within the American Indian Community, tribal administrators and health outreach workers are the key outreach contacts. Outreach is targeted to families and those who serve them through pow-wows and festivals. In addition, the State HC/NCHC Minority Outreach Consultant serves on the Institute of Medicine's Indian Health Task Force.

The African American population was targeted through minority-owned media during "Cover the Uninsured Week" this past spring. Marketing was placed to reach 21 counties with a high density African American population. Messages were disseminated through 5 newspapers, 7 radio stations, and 13 billboards. Fourteen press releases were sent to key media contacts in these counties. The NC Healthy Start Foundation also exhibited at an African American Women Empowerment Conference and at a large faith-based event.

Targeted outreach to minority populations will continue to be a major focus of the Campaigns as WCHS works with sister agencies on Title VI compliance issues, efforts to eliminate health disparities and culturally competent outreach strategies and materials.

Children with Special Health Care Needs are targeted through agencies and organizations that serve them. DPH administers the Children with Special Health Care Needs Help Line for those "living with, caring for, or concerned about children with special health care needs." The line provides information and referral, specifically focusing on state and local resources available for CSHCN. A marketing piece was developed in FY 05 for use in statewide outreach. The Family Support Network of North Carolina through its Central Directory of Resources, Toll-Free Line, Parent to Parent Network and other programs also serves CSHCN. Both market HC/NCHC and MH to this target population.

In the past year, the Children and Youth Branch, Division of Public Health updated and redesigned the companion piece to their SCHIP benefits book called "NC Health Choice: Information of Children with Special Health Care Needs and their Families." This booklet provides "Ideas for Making Things Work", "Frequently Asked Questions", "What to Do When Things Go Wrong"; "Important Phone Numbers and Other Resources."

Targeted outreach was also done at the North Carolina Special Olympics Games, at the Council for Exceptional Children's Conference, through the Schools for the Deaf and Blind, and other venues. Information has also been disseminated through targeted mailings, list serves, presentations and exhibits.

In addition to anecdotal data and feedback from focus groups and the targeted communities themselves, we have tracked an increase in enrollment numbers and continue to have a high volume of calls from each of these groups.

SUBSTITUTION OF COVERAGE (CROWD-OUT)

States with a separate child health program above 200 through 250% of FPL must complete question 1. All other states with trigger mechanisms should also answer this question.

1. Does your state cover children between 200 and 250 percent of the FPL or does it identify a trigger mechanism or point at which a substitution prevention policy is instituted? Yes _____ No __X___

   If yes, please identify the trigger mechanisms or point at which your substitution prevention policy is instituted. **[7500]**

States with separate child health programs over 250% of FPL must complete question 2. All other states with substitution prevention provisions should also answer this question.

2. Does your state cover children above 250 percent of the FPL or does it employ substitution prevention provisions? Yes _____ No __X___

If yes, identify your substitution prevention provisions (waiting periods, etc.). **[7500]**

All States must complete the following 3 questions

3. Describe how substitution of coverage is monitored and measured and the effectiveness of your policies.

   At application for NC Health Choice, a family may have private insurance but must terminate that coverage prior to enrollment. The child(ren)'s eligibility for Health Choice will not begin until the first day of the month following the month the child is dropped from the private insurance.

4. At the time of application, what percent of applicants are found to have insurance?

   Since this provision was implemented in February 2002, through September 30, 2005, a total of 206 NC Health Choice cases dropped private coverage.

5. Describe the incidence of substitution. What percent of applicants drop group health plan coverage to enroll in SCHIP? **Less than one percent of applicants drop coverage to enroll in SCHIP.**

COORDINATION BETWEEN SCHIP AND MEDICAID

(This subsection should be completed by States with a Separate Child Health Program)

1. Do you have the same redetermination procedures to renew eligibility for Medicaid and SCHIP (e.g., the same verification and interview requirements)? Please explain.

   North Carolina has the same re-determination procedures to renew eligibility for Medicaid and SCHIP. There is one application for re-determination that is returned to and processed by the county department of social services. It is reviewed based on family income by a county eligibility caseworker. IF the child is determined to be Medicaid eligible, the child is enrolled in Medicaid. IF the child is determined to be SCHIP eligible, the child is enrolled in SCHIP. The family is subsequently informed of the children's eligibility status and the child receives a card reflecting his or her eligibility status.

2. Please explain the process that occurs when a child's eligibility status changes from Medicaid to SCHIP and from SCHIP to Medicaid. Have you identified any challenges? If so, please explain.

   North Carolina's process is so seamless that the biggest problem we face is that on occasion a Medicaid family does not realize initially that the child has been moved into SCHIP from Medicaid or vice versa. However, the Medicaid card is larger and does not have the imprint of Blue Cross and Blue Shield of North Carolina as the SCHIP card does.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

   SCHIP in North Carolina uses any willing provider indemnity system so that a previously Medicaid child does not have to change physicians or other providers when moving into SCHIP from Medicaid. Medicaid has a broad network of providers and uses a PPO system. Medicaid also initiates reminder calls to patients for well- child checkups. NC Health Choice does not offer this feature.

Eligibility Re-determination and Retention

1. What measures does your State employ to retain eligible children in SCHIP? Please check all that apply and provide descriptions as requested.

_____ Conducts follow-up with clients through caseworkers/outreach workers

X
_____ Sends renewal reminder notices to all families
How many notices are sent to the family prior to disenrolling the child from the program?
____*4*___ **[500]**
At what intervals are reminder notices sent to families (e.g., how many weeks before the end of the current eligibility period is a follow-up letter sent if the renewal has not been received by the State?) **A post card is mailed to the family 10 calendar days before the re-enrollment form is mailed. The post card reminds that the re-enrollment form is coming and to return the form to the county department of social services. The re-enrollment form is mailed at the beginning of the 11th month of the certification period. A timely (10 day) notice is mailed if the re-enrollment form is not returned by the 25th day of the 11th month. This timely notice gives the family 10 work days to return the needed information. After the 10th work day, a notice is mailed to the family telling them the status of the child(ren)'s eligibility.**

_____ Sends targeted mailings to selected populations
Please specify population(s) (e.g., lower income eligibility groups) **[500]**

X
_____ Holds information campaigns

X
_____ Provides a simplified reenrollment process, (explained throughout report)
Please describe efforts (e.g., reducing the length of the application, creating combined Medicaid/SCHIP application) **[500]**

_____ Conducts surveys or focus groups with disenrollees to learn more about reasons for disenrollment
please describe: **[500]**

_____ Other*, please explain*: **[500]**

2. Which of the above strategies appear to be the most effective? Have you evaluated the effectiveness of any strategies? If so, please describe the evaluation, including data sources and methodology.

Please see previous section on outreach.

3. Does your State generate monthly reports or conduct assessments that track the outcomes of individuals who disenroll, or do not reenroll, in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured, how many age-out, how many move to a new geographic area)

__X__Yes

_____No

When was the monthly report or assessment last conducted?

A report "North Carolina Health Choice Re-enrollment Report Summary" is run twice a month. The following data is on statewide re-enrollment activity for the month of September 2005. Data from the first report is based on the pull check date and the second report data is based is as of the ten day grace period.

	Report One	Report Two
Total number eligible to reenroll	**13,695**	**13,695**
Total number who reenrolled	**5,946**	**7,432**
Percent of those reenrolled	**43.41%**	**54.2%**
Re-enrollees found eligible for Medicaid	**1,863**	**2,187**
Percent of those eligible found eligible for Medicaid	**13.6%**	**15.9%**
Those eligible to purchase extended coverage	**374**	**410**
Percent of those eligible to purchase extended coverage	**2.73%**	**2.9%**
Number terminated for failure to complete redetermination	**3,536**	**1,963**
Percent of those terminated for failure to complete redetermination	**25.81%**	**14.3%**
Number terminated for other reasons	**1,976**	**1,435**
Percent who terminated for other reasons	**14.42%**	**10.4%**
Number of children who moved out of North Carolina	**18**	**19**
Number of children who no longer meet age requirement	**26**	**32**
Number who failed to pay enrollment fee	**165**	**68**
Those with applications pended		**268**
Percent with applications pended		**1.9%**

If you responded yes to the question above, please provide a summary of the most recent findings (in the table below) from these reports and/or assessments. **[7500]**

Findings from Report/Assessment on Individuals Who Disenroll, or Do Not Reenroll in SCHIP

Total Number of Dis-enrollees	**Obtain other public or private coverage**		**Remain uninsured**		**Age-out**		**Move to new geographic area**		**Other**	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
6,263	2,597	41.5%			32	0.511%	19	0.303%		

Please describe the data source (e.g., telephone or mail survey, focus groups) used to derive this information.

The numbers above are derived from the September 2005 NCHC Re-enrollment Report Summary.

COST SHARING

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

   Denial codes and termination codes are used to document why applications for Health Choice and denied and assistance is terminated. For applications, failure to pay the enrollment fee is the number two reason why applications are denied, the first reason being other insurance and the third is income.

2. Has your State undertaken any assessment of the effects of cost sharing on utilization of health services in SCHIP? If so, what have you found? **No.**

3. If your state has increased or decreased cost sharing in the past federal fiscal year, has the state undertaken any assessment of the impact of these changes on application, enrollment, disenrollment, and utilization of health services in SCHIP. If so, what have you found? **No changes in past federal fiscal year.**

PREMIUM ASSISTANCE PROGRAM(S) UNDER SCHIP STATE PLAN

1. Does your State offer a premium assistance program for children and/or adults using Title XXI funds under any of the following authorities?

   Yes _____ please answer questions below.

   X No _____ skip to Section IV.

Children

____ Yes, Check all that apply and complete each question for each authority.
____ Premium Assistance under the State Plan
____ Family Coverage Waiver under the State Plan
____ SCHIP Section 1115 Demonstration
____ Medicaid Section 1115 Demonstration
____ Health Insurance Flexibility & Accountability Demonstration
____ Premium Assistance under the Medicaid State Plan (Section 1906 HIPP)

Adults

____ Yes, Check all that apply and complete each question for each authority.
____ Premium Assistance under the State Plan (Incidentally)
____ Family Coverage Waiver under the State Plan
____ SCHIP Section 1115 Demonstration
____ Medicaid Section 1115 Demonstration
____ Health Insurance Flexibility & Accountability Demonstration
____ Premium Assistance under the Medicaid State Plan (Section 1906 HIPP)

2. Please indicate which adults your State covers with premium assistance. (Check all that apply.)

____ Parents and Caretaker Relatives

____ Childless Adults

3. Briefly describe your program (including current status, progress, difficulties, etc.) **[7500]**

4. What benefit package does the program use? **[7500]**

5. Does the program provide wrap-around coverage for benefits or cost sharing? **[7500]**

6. Identify the total number of children and adults enrolled in the premium assistance program for whom Title XXI funds are used during the reporting period (provide the number of adults enrolled in premium assistance even if they were covered incidentally and not via the SCHIP family coverage provision).

_____ Number of adults ever-enrolled during the reporting period

_____ Number of children ever-enrolled during the reporting period

7. Identify the estimated amount of substitution, if any, that occurred or was prevented as a result of your premium assistance program. How was this measured? **[7500]**

8. During the reporting period, what has been the greatest challenge your premium assistance program has experienced? **[7500]**

9. During the reporting period, what accomplishments have been achieved in your premium assistance program? **[7500]**

10. What changes have you made or are planning to make in your premium assistance program during the next fiscal year? Please comment on why the changes are planned. **[7500]**

11. Indicate the effect of your premium assistance program on access to coverage. How was this measured? **[7500]**

12. What do you estimate is the impact of premium assistance on enrollment and retention of children? How was this measured? **[7500]**

13. Identify the total state expenditures for family coverage during the reporting period. **(For states offering premium assistance under a family coverage waiver only.) [7500]**

SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below, including the assumptions on which this budget was based (per member/per month rate, estimated enrollment and source of non-Federal funds). (*Note: This reporting period =Federal Fiscal Year 2005. If you have a combination program you need only submit one budget; programs do not need to be reported separately.)*

COST OF APPROVED SCHIP PLAN

Benefit Costs	**2005**	**2006**	**2007**
Insurance payments	**$275,812,039**	**$291,477,782**	**$339,382,792**
Managed Care			
per member/per month rate @ # of eligibles	**$168.85**	$196.74	$217.50
Fee for Service			
Total Benefit Costs			
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs	**$275,822,043**	**$291,477,782**	**$339,382,792**

Administration Costs			
Personnel	**51,695**	69,427	69,427
General Administration	**6,629,724****	1,424,251*	1,424,251*
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs	**550,935**	936,594*	936,594*
Other **[500]**			
Health Services Initiatives			
Total Administration Costs	**7,232,354**	**2,430,272**	**2,430,272**
10% Administrative Cap (net benefit costs ÷ 9)	**30,645,782**	**32,386,420**	**37,709,199**

Federal Title XXI Share	**210,981,290**	**220,901,294**	**256,906,699**
State Share	**72,063,102**	**73,006,761**	**84,906,365**

TOTAL COSTS OF APPROVED SCHIP PLAN	**283,044,393**	**293,908,054**	**341,813,064**

* This allocation is the maximum that the state will support for DSS and outreach.

** In FY 2005, the state allocated $1.4 million to county DSS agencies; however, DSS will support expenditures in excess of that allocation.

2. What were the sources of non-Federal funding used for State match during the reporting period?

- **X** State appropriations
- _____ County/local funds
- _____ Employer contributions
- _____ Foundation grants
- _____ Private donations
- _____ Tobacco settlement
- _____ Other (specify) **[500]**

SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)

Please reference and summarize attachments that are relevant to specific questions.

1. If you do not have a Demonstration Waiver financed with SCHIP funds skip to Section VI. If you do, please complete the following table showing whom you provide coverage to.

	SCHIP Non-HIFA Demonstration Eligibility					HIFA Waiver Demonstration Eligibility				
Children	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Parents	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Childless Adults	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Pregnant Women	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL

2. Identify the total number of children and adults ever enrolled (an unduplicated enrollment count) in your SCHIP demonstration during the reporting period.

_____ Number of **children** ever enrolled during the reporting period in the demonstration

_____ Number of **parents** ever enrolled during the reporting period in the demonstration

_____ Number of **pregnant women** ever enrolled during the reporting period in the demonstration

_____ Number of **childless adults** ever enrolled during the reporting period in the demonstration

3. What have you found about the impact of covering adults on enrollment, retention, and access to care of children?

4. Please provide budget information in the following table for the years in which the demonstration is approved. *Note: This reporting period (Federal Fiscal Year 2005 starts 10/1/04 and ends 9/30/05).*

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	**2005**	**2006**	**2007**	**2008**	**2009**
Benefit Costs for Demonstration Population #1 (e.g., children)					
Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #1					
Benefit Costs for Demonstration Population #2 (e.g., parents)					
Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					

Fee for Service					
Total Benefit Costs for Waiver Population #2					

Benefit Costs for Demonstration Population #3 (e.g., pregnant women)

Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #3					

Benefit Costs for Demonstration Population #4 (e.g., childless adults)

Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #3					

Total Benefit Costs					
(Offsetting Beneficiary Cost Sharing Payments)					
Net Benefit Costs (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)					

Administration Costs

Personnel					
General Administration					
Contractors/Brokers *(e.g., enrollment contractors)*					
Claims Processing					
Outreach/Marketing costs					
Other *(specify)* **[500]**					
Total Administration Costs					
10% Administrative Cap (net benefit costs ÷ 9)					

Federal Title XXI Share					
State Share					

TOTAL COSTS OF DEMONSTRATION					

When was your budget last updated (please include month, day and year)? **[500]**

Please provide a description of any assumptions that are included in your calculations. **[7500]**

Other notes relevant to the budget: **[7500]**

SECTION VI: PROGRAM CHALLENGES AND ACCOMPLISHMENTS

1. For the reporting period, please provide an overview of your state's political and fiscal environment as it relates to health care for low income, uninsured children and families, and how this environment impacted SCHIP. **[7500]**

   North Carolina continues to recover from job loss due to industry closures. In addition, working families continue to see reductions in work hours, increases in premiums from employer sponsored health coverage or decreases in dependent coverage. North Carolina continues to see large numbers of migrant families with SCHIP eligible children entering the state to find work and make a home. These are factors that result in the increased need for SCHIP in North Carolina. As access to health care has become a major concern of all families in North Carolina, it has been a priority of the Governor and General Assembly to ensure North Carolina Health Choice operates in the most effective manner to serve those families most in need.

2. During the reporting period, what has been the greatest challenge your program has experienced?

   The greatest challenge each year is to ensure the program continues with the limited funding available.

3. During the reporting period, what accomplishments have been achieved in your program? **[7500]**

   Enrollment of children in North Carolina Health Choice continues to increase at the average rate of one percent per month.

4. What changes have you made or are planning to make in your SCHIP program during the next fiscal year? Please comment on why the changes are planned. **[7500]**

   In 2005, the North Carolina General Assembly passed legislation effective January 1, 2006, that changes the North Carolina Health Choice for Children Program. Medicaid eligibility will expand to cover children age zero through five with family income of up to 200% of the federal poverty level. Children age 0-5 currently enrolled in SCHIP will be moved to Medicaid. North Carolina Health Choice for Children will continue to cover children age 6-18 whose family income does not exceed 200% of the federal poverty level. The delivery of services to Health Choice children age 6-18 will change. The children will be assigned to a primary care case management (PCCM) system.

   North Carolina will go from a separate SCHIP program to a combination of a separate SCHIP and Medicaid expansion. State legislation has also mandated a three percent growth cap per six month period on SCHIP enrollment.